City of St. Louis Employee COVID-19 Vaccine Incentive Program

Thank you for participating in the City of St. Louis Employee COVID-19 Vaccine Incentive Program! Getting vaccinated against COVID-19 is the best way to make sure you and your loved ones don't end up in the ICU. We can see the end of this crisis on the horizon, but only if enough people continue to protect themselves by vaccinating.

City of St. Louis employees who complete vaccination (x1 Johnson & Johnson, x2 Pfizer or Moderna) can receive **$100 in gift cards from the following: Target, Home Depot or Schnucks. Cards will be mailed to the employee's address of record.** Paid Time Off will be available to those who get vaccinated during work hours.

This will be available to City Civil Service employees who were **NOT vaccinated before July 26, 2021.**

To receive your $100 gift card, complete the form below and return it to your payroll clerk or to Employee Benefits 1114 Market Street, Suite 926, St Louis, MO 63101. If you return the form in-person at Employee Benefits, you will receive the card in-person. Due to HIPPA regulations, this form may ONLY be hand delivered by the employee.

The form attached is a medical record release authorization for the purpose of voluntarily disclosing your vaccination status to the City of St. Louis.

Instructions for submission of Authorization attached are as follows:

Employees must complete all fields accurately and legibly on the form.

The employee is the "patient" for purposes of disclosure of vaccine status on the HIPAA-compliant authorization form. The employee can submit the form to their agency's payroll clerk or Employee Benefits Section who will then mail employees their gift card.

Note: This form contains personal information and cannot be accepted via scanned document.

If you are untruthful about your vaccination status, you may face disciplinary action up to and including dismissal.

City of St. Louis Employee COVID-19 Vaccine Incentive Program
Eligibility Date, July 27, 2021

INFORMATION REQUIRED:

Name and Department

_____

_____

Email Address (optional):_____

Home or Cell Phone Number:_____

Date of Vaccination (provide one date for J&J and two dates for Moderna and Pfizer):_____

Check one:

__ I attest that I received one dose of a Johnson and Johnson COVID-19 vaccination.

__ I attest that I received two doses of a Pfizer or Moderna COVID-19 vaccination.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
SPECIFIC VERIFICATION OF COVID VACCINATION STATUS

Patient Name:
_____

Patient Date of Birth: _____ Patient SS# _____
(Optional)

I _____hereby authorize
(Patient)

Show Me Vax, Missouri's Immunization Information System

To disclose specific health information from the records of the above-named Patient to: The Director of Health of the City of St. Louis or his designee; the Director of Personnel of the City of St. Louis or his designee and the Employee Benefits Section.

For the specific purpose(s): of verifying the COVID-19 vaccination status of the Patient.

Specific information to be disclosed: COVID-19 Vaccination status of the Patient, including date of vaccination or vaccinations, and type of vaccine administered to Patient.

I understand that I may revoke this authorization at any time. If I want to revoke this authorization, I have to do it in writing and send it to the above specified Recipient who is authorized to receive the health information and/or to the person(s) who is authorized to disclose the health information under this authorization form. My revocation of this authorization, though, will not apply to any information that has already been disclosed before I have effectively revoked this authorization. Also, my revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date or event: Receipt of response of Show Me Vax.

If I fail to specify an expiration date or event, this authorization will expire in six (6) months.

I understand that any information disclosed under this authorization to above-related Recipient might not be protected by state or federal confidentiality or privacy laws or rules and could be re-disclosed by the Recipient.

I understand that if my record contains information relating to HIV infections, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, or behavioral or mental health services, this disclosure will NOT include that information.

I also understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. The covered entity/EMS may not condition getting treatment, making payments on any bills, enrollment in health insurance plan or eligibility for benefits on whether the individual signs the authorization, unless the Federal Privacy Regulations allow it.

A photocopy of this authorization may be used in place of the original.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print name of Patient or Personal Representative

_____

If signed by a Personal Representative, provide relationship and/or authority to act for Patient along with attached copies of legal documentation of that authority if the person is of legal age.